DOCUMENT RESUME

ED 215 236 CG 015 839

AUTHOR Zuehlke, Martha E.; Rogel, Mary J.
TITLE Adolescent Peers as Facilitators of Contraceptive Use.
PUB DATE 25 Aug 81
NOTE 15p.; Paper presented at the Annual Convention of the American Psychological Association (89th, Los Angeles, CA, August 24-26, 1981). Research was supported by grants from the Michael Reese Hospital and Medical Center and from the MacArthur Foundation.

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Adolescents; *Contraception; *Decision Making; *Females; Individual Differences; Intervention; Leadership Training; Peer Influence; *Peer Teaching; Pregnancy; Program Descriptions; Program Effectiveness; *Sex Education; Venereal Diseases

ABSTRACT

This paper describes the Young Adult and Adolescent Decision Making About Contraception program, an ongoing clinical research project designed to address the problem of unplanned adolescent pregnancy from a biopsychosocial perspective. The program is described as a peer-led intervention to promote the use of contraception by teenage girls at high risk for unintended pregnancy, designed on the basis of findings from a survey of girls (N=120) in the target population. A summary is included of survey findings which provides an assessment of important demographic, intrapsychic, and interpersonal factors differentiating successful contraceptors from unsuccessful contraceptors. The population is described, the intervention techniques are outlined, and perceptions of the strengths and weaknesses of the peer intervention are discussed. The content and peer group discussion format of the 12-week program are described along with the training and performance of peer leaders. General conclusions are drawn from the peer intervention experience and the success of the program is reviewed. (NRB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED215236

Adolescent Peers as Facilitators of Contraceptive Use [1]

Martha E. Zuehlke, M.D.

Mary J. Rogel, Ph.D.

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Martha Zuehlke

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

[1] The research presented in this paper was supported by grants from Michael Reese Hospital and Medical Center and from the MacArthur Foundation.

The Young Adult and Adolescent Decision Making About Contraception Project
The Laboratory for the Study of Adolescence
Michael Reese Hospital and Medical Center
2959 South Cottage Grove
Chicago, Illinois 60616

Symposium paper presented at the annual meeting of the American Psychological Association, Los Angeles, August 25, 1981.

CG 015839

Adolescent Peers as Facilitators of Contraceptive Use

The project I will describe and discuss today - the Young Adult and Adolescent Decision Making About Contraception program (Y.A.D.M.A.C.) - is an ongoing clinical research project designed to address the problem of unplanned adolescent pregnancy from a biopsychosocial perspective. The goal of the Y.A.D.M.A.C. project is to prevent unplanned pregnancy among teenagers. Over a million teenage girls become pregnant each year in the U.S. - 30,000 of them under 14 years old. Adolescent pregnancy and parenting have been shown to be associated with diminished attained level of education, diminished financial earnings, increased incidence of dependence on the state, increased incidence of divorce, increased incidence of repeat pregnancy and obstetric complications, increased incidence of delayed or abnormal development of the offspring and increased incidence of child abuse. While a number of centers are attempting to address the complex needs of the adolescent parent, her offspring and her family, there is surprisingly little work being done to attempt to intervene before the pregnancy occurs.

In the initial phase of this project we interviewed 120 girls in several outpatient clinics at Michael Reese Hospital and Medical Center in Chicago. We gathered information along six areas: demographic information; sexual and obstetric history; environmental pressures; decision making styles; personality items and sexual knowledge, attitudes and practices.[2] I will not discuss that phase of the project today except to summarize the factors we found most useful in differentiating girls who reported using contraception within one year of beginning sexual activity (the users) from those girls who waited longer than one year after beginning sexual activity or never used contraception (the nonusers). It was these factors around which we designed our peer intervention.

[2] We wish to thank Michelle Shelton and Maryse Tobin-Richards for their assistance in conducting the survey; Cecilia H. Bethe, Nina Holstein and Michelle Shelton for their participation in the intervention; and John P. Fleming and Charlene Weiss for data processing and analysis.

The user group disagreed that pregnancy depended on luck; they had a greater sense of their control over pregnancy occurring. Second, they had more accurate knowledge about contraception and conception. Third, they perceived environmental pressures to use contraception and avoid pregnancy; their friends and sisters had lower incidences of pregnancy in adolescence and were seen as being in favor of birth control use. These "user" girls knew what their family members' experience with contraception had been, although the nature of that experience did not correlate with contraceptive use status.

Previous studies have demonstrated the importance of adolescents' perceptions of their peers' attitudes and standards of behavior in the area of sexuality (Furstenberg, 1976; Kar, et al., 1979; McCance and Hall, 1972; Miller, 1973). Others have shown that peers are an important source of sex and contraceptive information and referral to appropriate clinics (Finkel and Finkel, 1975; Lindemann, 1974; Reichelt and Werley, 1975; Thornburg, 1972). It was our hypothesis that we could systematically enhance adolescents' knowledge and skills in this area and thereby serve to improve and reinforce a naturally occurring phenomenon.

Our focus today is on the use of the adolescent peer group to decrease unplanned adolescent pregnancy. Specifically, can the adolescent peer group be used to modify the attitudes and behavior of adolescents regarding sexuality and contraceptive use and, if so, how can this be accomplished?

I would like to describe our population, outline our intervention, discuss our perceptions of the strengths and weaknesses of the peer model in this type of intervention and draw some general conclusions from our experience.

We addressed our intervention to the population of adolescent girls served by the Michael Reese Hospital Clinics - a low-income, black, inner-city population with high rates of multiple social, economic and medical problems. We had been advised by our local colleagues that this population would not be interested enough to attend any type of program regularly. In fact, the majority of girls interviewed

in our initial survey did express interest in attending such a program. Of even greater interest is the fact that the girls did attend regularly, frequently brought friends and relatives with them, which we encouraged, and many requested to repeat the 12 week program.

The program itself is organized along two levels - content and format. The content of the curriculum includes information about sexuality and fertility, the real (vs. imagined) consequences of sexual activity, the options available for preventing pregnancy and V.D. and the consequences and options available for dealing with V.D., pregnancy and parenting. We begin with the idea of the decision to become sexually active. This is followed by an exploration of the possible consequences of sexual activity - V.D., pregnancy, contraception, abortion and parenting. Finally, more general issues of value clarification, decision-making and future planning are addressed as they relate to the issues of sexuality.

We designed the format to communicate and reinforce certain attitudes and behavio styles consistent with our desired outcome - that adolescents utilize their peers to help them to successfully avoid unwanted and unintended pregnancies. Groups were made up of 10-20 adolescent girls led by 2 to 4 adolescent peer leaders and assisted by one adult staff member. Each group met for 12 weekly sessions for 1½ - 2½ hours during after school hours. The staff provide an outline of each meeting including the goals, the basic information and exercises to facilitate getting the information or ideas across. Considerable emphasis is placed on opportunities to see, try out and practice new styles of decision making and behaviors within the meetings. The peer leaders ran the meetings themselves, utilizing the staff person only as she was needed.

The group discussion format allowed and encouraged participation from all involved in ways that one-way communication could not. Using adolescents as group

leaders conveyed and reinforced several messages: that acknowledging and appropriately dealing with sexuality is an adolescent task and decision, that adolescents can master the information needed to adequately deal with sexuality and that adolescents can communicate information and ideas about sexuality to other adolescents. We see these messages as essential prerequisites to modifying their behavior in this area. We were aware of the multiple levels of barriers in adult-adolescent communication especially in the area of sexuality (Rogel and Meara, 1981) and anticipated that the adolescent peer leaders would be able to avoid these barriers, allowing more honest and spontaneous exchanges to occur. In addition, we hoped their energy and enthusiasm for the task would create an atmosphere of "this is our project" in the sessions, giving a credibility and impact to the program that would not have been true without their contribution.

Peer leaders were trained for and given the expectation they would function as the leaders of their groups. They recruited participants for the project. They were expected to have worked out in advance of each session, usually with the help of their staff member, how they would conduct the meeting - for example, who would open the session and who would take responsibility for the various sections.

During the sessions the peer leaders opened the meetings, introduced the subject of the day, initiated and sustained discussions, brain-storming exercises, role plays and brought the meetings to a close with a summary or review of the session's material and its' relevance to the project as a whole. Whenever an outside expert, such as a family planning person or obstetrician provided input to the group, the peer leader introduced and assisted in the presentation. It was really the peer leaders' responsibility to run the program, turning to the staff person only as a back up resource.

In many ways we were very satisfied with the performance of our peer leaders.

They were enthusiastic and to a great extent did view the program as "theirs". They were able to recruit participants for the groups more successfully than we had been able to do. They were more successful in terms of numbers of girls recruited as well as in having a greater proportion stay with the program for the full 12 weeks. They conveyed their enthusiasum to their group members and were able in a comfortable, nonthreatening way to encourage the participants to introduce themselves and their guests. The peer leaders were consistently adept at initiating and sustaining active participation in the group excercises of discussions, brain-storming and role plays. They were successful at encouraging quiet girls to join in and attempting to limit girls who were overly dominating the discussion. With some intermittent input from the staff member, they could keep the discussion focussed well. They were able to confront a participant's irresponsible attitude or behavior without throwing around the weight of an "authority figure". Our peer leaders were consistently successful and very much enjoyed encouraging participation in role plays of, for example, a girl's struggle to decide on a contraceptive method or to try to discuss birth control with her boyfriend. They were able to communicate the seriousness and relevance of the issues involved but to make it a fun activity.

Frequently the curriculum outline suggested some method of recording for the group what was being said; for example, lists of reasons to decide to have sex vs. reasons to decide not to or the benefits or advantage of some contraceptive vs. the costs or disadvantages. Lists or diagrams would be put on the blackboard and left for rechecking or altering. The peer leaders were enthusiastically active in this capacity but, as I will discuss shortly, their enthusiasm was not

entirely a plus.

Following an excercise to focus the group's attention and energy, the information or content of the session would be presented. Many peer leaders were very successful with this, for example, being able to explain in age-appropriate language and idiom reproductive anatomy and biology, contraceptive methods or the facts about abortion.

Overall, we felt satisfied and comfortable with how our peer leaders led but there were a number of consistent difficulties as well.

We stressed in the peer leader training the importance of reliabibility in terms of attendance, promptness and performance. This required ongoing emphasis. Beginning the meeting required shifting the mood from one of multiple conversations and the considerable activity in and around the room, to one of focussed attention. This was consistently a major task for the peer leaders; frequently they required some encouragment from the staff member to do this. Once some degree of order was obtained a brief greeting and orientation to either the program as a whole or the focus for the day was given. This was also an area of potential weakness as the girls had trouble synthesizing clear explanations or descriptions if they had not prepared in advance.

A pattern representative of their are of relative weakness involved their egocentricism. They assumed the members knew what we were trying to do or why, since they, the peer leaders, knew. Frequently we found that unless time and attention were specifically directed at going over what the purpose of a particular topic or activity was, the peer leaders would not be able to see or suggest one. They tended to plunge in and go through the material without sharing with their group members what this had to do with anything else

in their lives. On the other hand, if we, as staff, did go over this with the peer leaders in preparation for the session, they would then be able to convey this to their groups, with the result of better response and participation from their members. Interestingly, this ability was apparently never internalized as a useful technique or procedure by the peer leaders; they would omit explaining or making connections repeatedly, despite apparently grasping the value and purpose of this. To a certain extent this epitomizes what was consistently the most difficult task for the peer leaders - grasping the connections between ideas and the group's activities and conveying these abstract connections to their group members.

The difficulties with the 'record keeping' function, that is, the lists and comparisons generated in the discussions was another problem area. Our idea was to be as explicit and as repetitive as we could be without offending or boring the girls. While using the blackboard did offer the opportunity of summarizing and reflecting, it frequently seemed to stifle thought and free-flowing disucssion somewhat. Comments would be reduced to recordable phrases that seemed to convert a discussion to a barrage of "one-liners". There would be a tendency to discard or reject "incorrect" ideas or feelings and omit them from the recording. Unless some attention was paid to it in the preparation time, the peer leaders could easily get overly caught up in the mechanics of the board work and then lose the attention and energy of the group. Helping the peer leaders plan in advance how the peer leader doing the writing on the board wanted her co-leaders to assist her to keep the disucssion moving was an important task for the staff member. At times the staff member would need to step in during the meeting itself to facilitate this, apparently because the power associated with controlling the blackboard was more immediately gratifying to the peer leaders than being a facilitator of the group's process.

Each session would be concluded by the peer leaders conducting a group exercise designed to integrate the information that had been provided with some relevant aspect of the girls' lives. Having the girls use the information they had been given allowed for our immediate assessment of their perceptions and conclusions and for the possibility of immediate corrective feedback. It made concrete the relevance of the material and met many girls' needs for functioning as a responsible individual in a setting strongly supportive of this. While our peer leaders were consistently successful and very enthusiastic about encouraging their group members to participate in these exercises, they would tend to allow the exercise to speak for itself; That is, unless preparation was done each time with the staff member, little or no effort would be made by the peer leaders to clarify the points, make connections or draw summary conclusions from the exercise to the program's goals.

Given how pivotal our peer leaders were to the program, I would like to discuss some of the primary features of the training we offered these girls. Potential peer leaders were assessed for characteristics of interest in such a role, ability to express themselves in a group and deal with opinions different from their own, and reliabiltiy. We have required peer leaders to complete the 12 week program as a group member; this gives us the opportunity to observe their functioning in a group setting while they become familiar with the goals and methods of the Y.A.D.M.A.C. project. There have consistently been more girls seeking to be leaders than we could use. Most continue to want to be leaders after their first experience, so some girls have led several groups.

We attempt to pair peer leaders in such a way as to complement their different strengths and weaknesses; for example, we would pair a highly active,

charismatic or domineering girl with a more subdued, thoughtful or cautious girl. Final decisions about selection and pairing are made during the training period which immediately precedes each 12 week program. Adolescents change, and a girl sometimes surprises us with changed attitudes, priorities or abilities so that the closer the selection is done to the actual beginning of the intervention, the more likely it is that it will be successful.

During the 4 to 6 weeks spent in training the girls meet as a group that is organized to function similarly to the intervention groups. Goals are suggested by the staff and discussion, brain storming, and role plays are used to encourage the girls to work out leadership strategies, anticipate problems and evolve solutions. The problems of stimulating activity in overly inhibited groups and restraining and focusing activity in overly active groups are addressed by staff members. Role playing sections of some of the sessions provides practice and a medium for group and staff feedback. Some role plays are video or audiotaped so the girls can actually see themselves. The staff participate actively in the training, for example, modeling how one leads a group and facilitates group process and playing roles of "trouble makers" that require "on your feet" problem solving by the leaders. The girls frequently perceive this role-played behavior as unfair or hostile. If attended to, this provides a prime opportunity to focus on the issue of how to deal with anger as a peer leader. Learning to handle challenges to their position as the authority or expert and to deal with apathy or passivity within the group require more time and attention in peer leader training than do teaching the mechanics of providing the information. While we do support girls' attempts to develop their own styles of leadership, we see that they tend to model themselves after the styles of group leadership we present to them.

Training does not stop at the end of the designated training period; it continues, in another form, throughout the 12 weeks. Several peer leader meetings are held during the 12 weeks to discuss common problems, but most of the ongoing training takes place between the coleaders and their individual staff member.

It is very important for the staff person to establish a close working relationship with her peer leaders. It is necessary for the staff to be available by phone or in person between meetings to handle questions, interpersonal upsets and generally to enhance the leaders' feelings of involvement. For many of these girls, participating as a peer leader became an important aspect of their identity and self-esteem. This, of course, was a beneft in terms of their interest and commitment to the program but, at times, it led to some problems as well. Frustrating experiences with their group members or disappointed expectations of themselves or of their group could easily become magnified so that phenomena secondary to group dynamics would be interpreted and responded to personally. This might surface during a session when it could be dealt with directly or might only be acknowledged by the peer leader outside of the regular session. In fact, it appears the more contact between the staff member and the peer leaders - both formally in terms of preparation for sessions and informally before, after or between meetings - the better the peer leaders were able to function. Restoring self confidence damaged by not getting an expected behavior or response, which was felt as a personal attack or injury, and encouraging expression (ventilation) of feelings about how the group was going were ongoing tasks for the staff members.

Clarifying aspects of the group's dynamics served to enhance the peer leaders' observational skills, reduce some of their burden of responsibility

and improve the flow of the sessions. It did not appear that we were able to impart much of our conceptualizations of group process to our peer leaders; They rarely anticipated problems or processes within the group, nor were they able in retrospect to assess a situation independently. Consistently, they needed the observations, clarifications and connections made by their staff member. This frequently left the staff member feeling she was always trying to catch up with the current problem instead of having averted it. We were also unable to facilitate abstract thinking capabilities in our peer leaders, as I noted previously. If the premeeting planning time included specific attention to how to communicate the general ideas underlying a specific exercise, our peer leaders were able to communicate this to their groups, but without staff direction and support for this, they were not.

It is clear from this that the staff member played a pivotal, if at times indirect, role in the functioning of the groups. In addition to being able to encourage, support and teach her peer leaders, she herself needed to be familiar with and comfortable with group dynamics. Being a group leader is not an easy task. Trying to be the peer leaders' leader while allowing the peer leaders to lead a group process toward a specified goal requires multiple levels of observation and participation. It combines aspects of functioning as a therapist, teacher, supervisor, colleague and employer. We found peer leader-staff relationships were strongly positive and characterized by identification with the staff member on the part of the peer leaders.

In summary, we feel that our intervention has successfully utilized normative features of adolescent peer pressure and role models to educate and offer behavioral alternatives to adolescents in the area of sexuality. This is by

no means a simple or easy solution, however, as it requires considerable time, energy and resources of professionals able to function simultaneously in multiple roles. At the same time, however, we do not see evidence that suggests we were successful at teaching the girls - peer leaders or participants - to internalize capacities related to formal cognitive operations. We would encourage others to consider a peer model approach, not as a cheap and easy solution, but as a complex and goal-oriented intervention.

References

Finkel, M.L. and Finkel, D.J. Sexual and contraceptive knowledge, attitdues and behavior of male adolescents. Family Planning Perspectives. 1975, 7 (6), 256-260.

Furstenberg, F.F. The social consequences of teenage parenthood. Family Planning Perspectives. 1976, 8 (4), 148-164.

Kar, S.B., Marcus, E., Rykwalder, A., Serko, L., & Tell, E. Pregnancy risk-taking among young unmarried women: An analysis of its determinants and prevention. Patient Counseling and Health Education. 1979, 1 (4), 151-163.

Lindemann, C. Birth Control and Unmarried Young Women. New York: Springer Publishing Company, 1974.

McCance, C., & Hall, D. Sexual behavior and contraceptive practice of unmarried female undergraduates at Aberdeen University. British Medical Journal. 1972, 2 (5814), 694-700.

Miller, W.B. Sexuality, contraception, and pregnancy in a high school population. California Medicine. 1973, 119 (2), 14-21.

Reichelt, P.A., & Werley, H.H. Contraception, abortion and venereal disease: Teenagers' knowledge and the effect of education. Family Planning Perspectives. 1975, 7 (2), 83-88.

Rogel, M.J., & Meara, H. Barriers in adult-adolescent communication about sex-related issues. Transitions. June 1981, 2-4.

Thornburg, H.D. A comparative study of sex information sources. Journal of School Health, 1972, 42, 88.